

**Application for License to
Operate a Long-term Care Facility**

For Office Use Only
Received 10/24/11
Amount 2160.00

#12425

I. IDENTIFICATION

Name Regency Care of Mount Sterling LLC dba Windsor Care Center
125 Sterling Way
Address _____
City/County/Zip Mount Sterling / Montgomery / 40353
859-498-3343
Telephone number administrator@windsorcare.com
Administrator Rebecca L. Cooley
Date facility operation began at current address 10-01-1976
Date facility began operation under current owner 04-01-2010

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	<u>144</u>	<u>144</u>
Intermediate Care	_____	_____
ICF/MR	_____	_____
Personal Care	_____	_____

II. CONTROL (check one in each column)

State	Profit <input checked="" type="checkbox"/>	Individual
County	Nonprofit	Partnership
City		Corporation
Private <input checked="" type="checkbox"/>		LLC <input checked="" type="checkbox"/>

II. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners.

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OFFICE OF INSPECTOR GENERAL

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32

If facility owned or leased by a corporation, complete the following:

Name of corporation Regency Care Holding, LLC

Address of corporation P.O. Box 1667, 1978 Eighth Ave NW, Hickory, NC 28603

President or Chairman Steven D. Womack

Vice President _____

Secretary _____

Treasurer _____

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility.

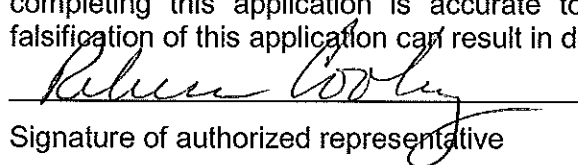
If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner.

Name and address of parent corporation and/or management company, if applicable.

Parent	Management Company
_____	WW Health Care Consultants, LLC
_____	<u>P.O. Box 1667</u>
_____	<u>Hickory, NC 28603</u>

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time. I agree that this facility and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.


Signature of authorized representative

<u>Administrator</u>	<u>10/27/11</u>
Title	Date

Return Application and fee to:

Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

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